ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Health and Human Services System and the Nebraska Rural Health Association for all rural health stakeholders

Issue 42, October 2005

How does the Economic Activity of the Health Care Sector Contribute to Your Community?

A Follow-up on the Nebraska Rural Health Works Project

By Roslyn S. Fraser-Maginn, M.A., and Li-Wu Chen, Ph.D.

Try to think of all the ways in which health care entities in your community interact with other sectors of the economy. What do they purchase within the county? What do they sell? Whom do they employ? Where do those employees spend their money?

What about outside the local economy? What does your local health care sector buy and sell across county lines and across state lines? How does this economic activity contribute to your community?

When you really think about it, these interactions become complex. And yet these questions are extremely important to ask because a community with a strong health care sector has a healthier population, experiences job growth in all economic sectors, and can attract businesses and retirees who spend money. Using an economic input-output analysis model and IMPLAN software, we are able to estimate the direct and indirect

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also in this issue . . .

Telehealth: It's Only Just Begun

By Dave Howe

Imagine if Thomas Alva Edison and his contemporaries, after developing the first practical incandescent light bulb, had simply brushed their hands together and exclaimed, "Good enough!" You might be reading this by the light of an electrified, carbonized cotton thread encased in a hand-blown glass bulb.

Or imagine Henry Ford concluding that the Model T, practical as it was at the time, was all that an automobile needed to be, while he and fellow automotive pioneers failed to press beyond the transportation door they had opened? Your auto trips might still begin with hand-cranking a cantankerous engine that pulls you along at 25 mph.

Of course, people of vision have never allowed such revolutionary concepts to stall and stagnate.

How the Nebraska Statewide Telehealth Network (NSTN) compares with such epochal events as inventions of the light bulb and the automobile is for you to decide. But a cadre of visionaries from such fields as healthcare, information technology, and administration are not about to declare, "Good enough!" even though the NSTN is largely in place and performing dramatic tasks such as the following:

Bringing physicians, nurses, and other highly trained healthcare personnel from all corners of the state together electronically through interactive video conferencing; moving health records and diagnostic test reports across secure, high-speed data lines among healthcare providers and institutions; making possible one-on-one interactive sessions between mental healthcare providers and their clients in rural areas where lack of such services and long distances are an obstacle to face-to-face visits; linking members in the healthcare field with the broad range of resources in the Nebraska Health and Human Services System (HHSS); electronically "transporting" an oral surgeon to a surgical suite hundreds of miles away for a consult with a dentist performing a complicated dental procedure with the aid of the net-

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Rural Health Works *cont'd from p. 1*
impact of the health care sector on jobs, income, and output of local and state economies.

With funding from the Nebraska Office of Rural Health, researchers at the Nebraska Center for Rural Health Research are creating, by request of the county, county-specific economic profiles under a project called Nebraska Rural Health Works. Based on the results from 41 counties, researchers have found that for each job created in a Nebraska county's health care sector, an additional 0.31 to 0.81 of a job is created within the county in other sectors of the economy. Likewise, for each $1 earned in income in the health care sector of a particular county an additional $0.21 to $0.58 of income is earned in other sectors within the county. Finally, for each $1 spent in a Nebraska county's health care sector, an additional $0.35 to $0.86 is spent in other sectors of that county's economy.

The heath care sector ranks seventh in overall (i.e., direct and indirect) impact on job creation in Nebraska (228,200 jobs) and sixth in overall impact on income creation ($9.98 billion), based on our statewide analysis. Furthermore, the health care sector contributes directly to seven percent of Nebraska's gross state product and has an overall contribution of 19 percent ($11.48 billion) after researchers account for multiplier effects.1

How Communities Are Using Their County Profiles

Nebraska communities are using their economic impact profiles as reference tools for grant writing, to aid in the rural health clinic certification process, and to bolster federally qualified health center (FQHC) applications. In particular, one Nebraska county requested its report to supplement data in a presentation to appeal for a public bond to expand hospital services.

Members of another county hospital, including board members, medical staff, and department leaders, used their county economic profile for strategic planning and identifying the health needs of community residents. The hospital CEO said the profile was influential in the hospital's decision to expand diagnostic testing and disease management programs.

Finally, another county hospital CEO published an article in a local newspaper reporting selected data from the county economic profile in order to increase awareness among community members of the economic impact of the health care sector.

Examining Rural Economic Viability

The concepts of the Nebraska Rural Health Works project are important from the perspective of rural economic viability because the rural economy relies, in part, on the health care sector. Rural hospitals are financially vulnerable because of high rates of uninsurance in rural areas, high levels of uncompensated care, and exposure to a small market with a disproportionately large elderly population.

Results of the household survey that was conducted as part of the Nebraska State Planning Grant indicate that the rate of uninsurance is higher in rural areas of Nebraska than in urban areas. Among Nebraskans younger than 65 years, the uninsurance rate was 11.1 percent for individuals living in non-metropolitan counties and 8.7 percent for individuals living in metropolitan counties. Hospital closure combined with high

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Nebraska Medical Association Educates Physicians about Telehealth

By Carole Bates

This spring, the Nebraska Medical Association (NMA), whose membership includes nearly 3,000 Nebraska physicians, formed a subcommittee of the NMA's Mental Health Task Force to address educating physicians about the state's telehealth network. The first project of the subcommittee was to survey members about their knowledge of the network and other items such as reimbursement by Medicare, Medicaid and private insurance companies. The survey results also determined what physicians across the state are currently using telehealth and in what nature.

Thirty-six percent of the physicians who responded were aware of the telehealth system. Twenty-four percent were aware of reimbursement by Medicaid; 21 percent by Medicare and 23 percent by private insurers.

In an effort to raise awareness about the system and its uses, the Nebraska Medical Association Subcommittee on Telehealth created a white paper that will be sent to all member physicians. This white paper includes information on reimbursement, services available over the network, regulations, how to schedule a telehealth consult and several other resources. We expect this white paper to increase awareness of the system with our members and ultimately increase use of the system so that our member physicians can continue to provide care for their patients.

For more information please contact the Nebraska Medical Association at (402) 474-4472. □

Pioneering a new route to better healthcare

By Dave Howe

The following line, familiar to *Star Trek* fans, comes to mind as you study the Panhandle Regional Health Information Plan that recently received a $1.5 million, 3-year grant for implementation: "Going where no one has gone before."

The money will be used to carry out a plan for exchanging electronic health information among a full spectrum of healthcare providers in western Nebraska. Doing that successfully will mean raising the quality and lowering the cost of healthcare, by minimizing the chances of redundant or incompatible treatments among a patient's various sources of healthcare.

"This is no 'plug in and play.' We are truly innovating this whole concept, particularly in rural areas," said Nancy Shank, Associate Director of the University of Nebraska Public Policy Center. The Center's role in this grant-funded effort includes evaluating and monitoring the planning process, which began a year ago under an AHRQ (Agency for Healthcare Research and Quality) grant.

That led to the just-announced $1.5 million AHRQ grant to cover costs of implementing the plan.

Lessons learned in how best to put all of the pieces together for sharing health records in real time—secure and in compliance with HIPAA--among all healthcare providers aren't necessarily intended to remain in western Nebraska. Instead, the focus is on developing a concept that can be adapted not only to other parts of the state but nationally, particularly for rural areas, Shank said.

Experience in what worked and what didn't will be readily shared with others who are interested, added Joan Frances, Director of the Rural Healthcare Cooperative Network (RHCN). She and Shank share responsibilities as directors of the planning process under AHRQ funding in the Panhandle, as noted in February and May 2005 Access newsletter articles on AHRQ grants for developing healthcare record-sharing systems.

The focus on collaboration and information sharing is clearly evident in an executive summary of the Panhandle Regional Health Information Exchange plan. An example is this passage: "Indeed, we understand that this collaborative partnership is developing a model that other rural areas across the United States will find instructive."

The Panhandle project and one in eastern Nebraska were two of just 38 AHRQ grants awarded nationally for planning an electronic medical records-sharing system a year ago. The Panhandle plan is one of only about 12 nationwide to receive implementation grants.

A second Nebraska winner of an AHRQ planning grant, this one in eastern Nebraska, was not awarded an implementation grant.

Just as collaboration was an overarching theme under which all stakeholders (hospitals, clinics, physicians, behavioral healthcare providers, and healthcare administrators) developed the healthcare record-sharing plan, it continues in the implementation phase, Shank and Frances emphasized.

She and Francis said they believe that collaborative emphasis carried a lot of weight with grant application reviewers in selecting the Panhandle plan for an implementation grant.

"The wonderful thing about people in western Nebraska is that they are so generous and expansive," Frances said. "We don't think it makes sense to put boundaries on this. We are prepared to share what we've learned with others around the state. We see this as an opportunity."

Information technology is a critical part of developing the shared electronic healthcare records. But it's about more than the technology. It's also about legal agreements, HIPAA, protocols, procedures, policies, and many other issues that go into assuring that health information-sharing

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Implementation participants include the following:

Box Butte General Hospital, Alliance
Chadron Community Hospital, Chadron
Garden County Health Services, Oshkosh
Kimball Health Services, Kimball
Memorial Health Center, Sidney
Morrill County Community Hospital, Bridgeport
Perkins County Health Services, Grant
Regional West Medical Center, Scottsbluff
Panhandle Partnership for Health and Human Services
Panhandle Public Health District
Region I Behavioral Health
Panhandle Mental Health Center
Region I Mental Health and Substance Abuse
Panhandle Community Services Health Center
University of Nebraska Public Policy Center

Rural Health Works *Cont'd from p. 2*

rates of uninsurance in a rural area led to physician loss. When local rural communities lose facilities and providers due to increasing rates of uninsurance, economic viability is placed at risk.

Analysis of one Nebraska county illustrates how hospital closure affects jobs and associated income as well as economic output in an area. In this simulation analysis, we examined the economic impact of one hospital closure in a Nebraska county with a population of approximately 9,500. The total economic impact, direct and indirect, of the closure of one hospital was a loss of 50 jobs, a loss of $980,000 in income, and a loss of $2.2 million in economic output for that county.

In this particular county, the impact of the hospital closure was tempered by the transfer of some jobs, income, and output to a remaining hospital within the county, which is reflected in our analysis. However, the magnitude of the impacts of the health care sector still decreased with the single hospital closure, showing that rural economic viability relies in part on the strength of the local health care sector.

How to Obtain a County Profile

A profile for your community may already be complete. To find out, visit the project Web site at http://www.unmc.edu/rural/NeRHW. County-level health economic profiles will be prepared by request. Those communities interested in requesting a profile can contact Li-Wu Chen, Ph.D., (liwuchen@unmc.edu) or Roslyn Fraser, M.A., (rfraser@unmc.edu) at the Nebraska Center for Rural Health Research, University of Nebraska Medical Center, (402) 559-5260. □

Telehealth *cont'd. from page 1*

work and an intra-oral camera in the patient's mouth.

A "backbone" is the metaphor applied to the NSTN communications structure that makes all of this possible. Think of a nerve trunk along which connections carry messages back and forth to all extremities.

The biggest issue for the NSTN right now is completing that backbone, said Dr. David Lawton, Health Surveillance Section Administrator in the Nebraska HHSS. It's only a matter of wrapping up a few key components — switches, T1 lines, and routers — here and there along the backbone. "Once all of those are in place, we'll have the backbone complete," he said. "We're pretty close to getting this thing finished. We have 85 to 90 connections on the network, and we're probably headed to 120."

"I think there is an interest in and a proactive movement by people involved ... to continue to move us forward," said Lt. Governor Rick Sheehy about the NSTN. One of his roles as lieutenant governor is chairing the Nebraska Information Technology Commission (NITC). He also serves on the advisory council to the NSTN and has been involved with the concept of telehealth for some time, going back to when he served on the board of directors of the Nebraska Rural Health Association, an early proponent of telehealth as a way to deliver rural health services.

As for development of the NSTN, he said, "It's important that we continue to look at advances in technology, to be sure we are as creative and proactive as possible ..." He mentions a need to explore satellite services for rural areas in which T1 lines and fiber optics that are central to the NSTN today are not readily accessible. "We have a good foundation model," he adds. "But this isn't the time to rest. Improvement is an on-going task."

And, the NSTN isn't resting. It's pressing ahead with improvements. Responsibility for facilitating development and improvement of the network falls to Dave Glover, who was hired for the job by the Nebraska Hospital Association.

Early-on in development of the network, federal funding to combat bio-terrorism was channeled into the network under the auspices of the Nebraska Information Technology Commission, which was chaired by then-Lt. Governor Dave Heineman. The commission made a pivotal decision at that time to use federal funding to contract with the Nebraska Hospital Association, which hired Glover as a telehealth network consultant.

Contracting with the Hospital Association not only qualified the network for funding directed against bio-terrorism but also gave the network a "visible leader" in the form of the association, Dr. Lawton said. He sees that move as a key step in development of the NSTN. "I tell other states (who are developing a telehealth network) that they need an external facilitator." It's critical to bring together the many disparate entities that a successful telehealth network involves.

The several-year journey to this "backbone closing" has been complex and arduous in both technological and financial terms, he said. Buying down the monthly cost of T1 lines to an affordable level for hospitals, particularly smaller rural hospitals with thin financial margins, is crucial to making the NSTN a reality. That money, provided through the Nebraska Public Service commission, comes from the State Universal Service Fund.

Numerous other agencies and a variety of grant money sources have had to come

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Telehealth *cont'd. from page 4*
together to underwrite cost of equipment, salaries, and technological expertise, to ensure that the entire state is covered, Dr. Lawton continued. All federal and state grant sources total nearly $1 million. That's in addition to the annual $900,000 data line buy-down provided by the Universal Service Fund. "It's a very collaborative effort."

Although the NSTN is already operating in many capacities across the state, the next step, called "Phase II," is the current focus of the network's advisory council. That includes adoption of a business model for the NSTN. As noted in the July issue of this newsletter, the choice of a business model will have an impact on the NSTN's potential role not only in the healthcare field but also in homeland security and educational services and as a gateway to institutions like the Centers for Disease Control and Prevention and other prominent healthcare entities such as Johns Hopkins University and the Mayo Clinic.

"We are still moving forward," Glover said. The NSTN Advisory Council has already decided that the business model will be some type of not-for-profit organization, such as a cooperative or a 501c (tax-exempt) organization, he adds.

However, detailed decisions pertaining to the NSTN's business model are continuing beyond the originally planned July completion date you read about in the last issue of this newsletter, Glover said. "You have to look at the big picture—that in five years, being a month or two behind (now) won't matter." Getting it done right in the early stages is more important to the long haul, he emphasized. That process involves contracting language and other legal/administrative details preparatory to fully implementing the NSTN, Glover said.

The NSTN Advisory Council is gathering information and preparing questions for outside legal counsel, addressing matters such as: Who will have access to the network? What financial resources will be available to it? What should the network administrative structure be? What legal liability and confidentiality issues need to be addressed? And how would federal and state regulations affect the network?

The NSTN is exploring a number of roles it will soon play or can eventually play. Right now, for instance, a statewide committee of the Nebraska Health Information Initiative (NeHII) is looking at the process of shared electronic health records among patients' healthcare providers. Shared records allow coordination of care among a patient's providers, to enhance that care and avoid conflicting and redundant treatments. The NSTN has been asked to join the committee in this discussion, which was organized by the Nebraska Hospital Association and other health groups, Glover said.

The NSTN's capabilities might be tapped for additional roles — by the state's correctional facilities, for example. Other roles may include participating in Homeland Security alerts within the state; issuing health alerts; and dispersing health information through the Nebraska HHSS via links with state public health agencies, the state public health lab located in the University of Nebraska Medical Center (UNMC), and the seven regional public health labs located around the state.

Those connected through the NSTN have their cost of T1 lines and fiber optics subsidized to affordable levels by the Nebraska Universal Service Fund administered by the Nebraska Public Service Commission, but there are other network costs. Equipment updates and maintenance, salaries for network technicians, administrative oversight of the network, and education for network users must all be paid for. Through Nebraska's congressional delegation, the NSTN hopes to see approval of an annual grant of $875,000 to cover those costs. Glover said the NSTN hopes to learn by this fall whether that grant is approved as part of the federal budgeting process. If it is, the funding would begin in October 2006.

Meanwhile, training for users of the NSTN is being coordinated through the UNMC and the following seven hub hospitals in the state: Regional West Medical Center in Scottsbluff, Great Plains Medical Center in North Platte, Good Samaritan Hospital in Kearney, Faith Regional Health Services in Norfolk, St. Francis Medical Center in Grand Island, and BryanLGH Medical Center and St. Elizabeth Medical Center in Lincoln. Training at those sites will begin with their own staffs and the staffs of hospitals associated with them, Glover said.

Standardized training and materials will be used by those hospitals. At the same time, the Nebraska Medical Association is developing training specific to the physician community, he added.

Meanwhile, development of a NSTN web site is progressing. Expected to be online either by the time you're reading this or soon afterwards, the site will serve both the public and healthcare providers, Glover said. The public will have the opportunity to ask about telehealth network services, for example. Healthcare providers can use the site for education session postings and many other types of information exchanges in their professions. □

Nebraska: Provider training issues

By Dr. Bob Bowman, UNMC

Nebraska is a Brighter Future qualified state demonstrating superior investment in the future of children and those who will become serving young professionals. Brighter Future states are also taking care of their own education and health needs and depending less upon other states and nations. (Report for all states available with rankings and analysis.)

Nebraska has the highest rural high school graduation rate in the nation, and also not surprisingly leads in the highest ratio of medical school admissions of those born in the non-metro areas of the state. (Reports for all states with rural populations available.) The state ranks second in per capita in-state medical school positions (behind West Virginia) and UNMC ranks in the top ten in percentage of rural physicians and total rural physicians.

Nebraska's public medical school ranks fifth in the nation in breadth of admissions (rural born, older, in-state born) and supplies six of the seven physician types most needed in rural areas. The state has preferential admissions of rural high school students directly to medical school and funneled through two state colleges in rural areas. The school has recently experienced increases in MCAT level with decreasing admissions of rural born students and has expanded the rural high school admissions efforts. The best counties in the state at admitting medical students are suburbs around Omaha, Lincoln schools, schools in large rural cities along Interstate 80, and a scattering of mid-sized rural towns. (Report and rankings by county available.)

Few if any medical schools come close to the breadth of primary care training programs that have diversified and decentralized to meet the needs of the entire state from inner city to rural training track to accelerated programs to combined primary care programs. The state's efforts have managed to produce a balance between the needs of rural areas and graduation of rural family physicians. The geriatrics training is particularly outstanding, a great asset for a state where many counties have more than 20% over age 65. The procedural training was solid, but is now improving greatly in the family medicine programs with graduates meeting the needs of rural areas for physicians who can do endoscopy, colposcopy, and obstetrics. The state's high successful accelerated rural training program was forced to change operation as this effective model was terminated by national accrediting bodies. No other training model in the nation has demonstrated the ability to graduate over 85% into rural locations or urban poverty locations. Nebraska's model was the only one that survived, but it will be a few years before any changes in outcomes are known.

Overhead costs for primary care are reasonable and state primary care salaries are higher, particularly for physicians in rural areas. The state has the third lowest average liability claim cost in the nation. Despite this ranking, the liability premiums in the state have recently increased, a function of fewer insurance providers. Nebraska ranks in the middle regarding claims per physician and claims per 100,000 population. Like others with recent increases, physicians are moving to self-insurance where possible.

Nebraska, like many Midwestern states, has to import psychiatrists and the state is preparing a mental health plan to attempt to improve mental health access. Also, Nebraska loses a significant portion of school teachers to higher paying school districts in Texas and California each year.

Nebraska is dead last in the nation in state share of education with only 38% of education funding provided by the state. This leaves rural and inner city and low property value areas of the state vulnerable in education funding, particularly with recession or local economic setbacks. Where children are lower income and disadvantaged, studies demonstrate that they can have the same education outcomes with 40% more education funding. Sadly, most get even less funding and are now held responsible despite inadequate funding to meet the challenge.

How will we train future health care partners?

For more information, or to share ideas, contact Dr. Bob Bowman at rbowman@unmc.edu □

Medicaid Reform Planning Public Input Meetings

Most meetings begin at 7:00 p.m. local time.

Oct. 25, 2005 - Omaha
TAC Building Board Rm., 3215 Cuming St.

Oct. 26, 2005 - Lincoln
State Capitol, 1445 K Street, Room 1510

Oct. 27, 2005 - Grand Island
City Hall - Community Meeting Room
100 East 1st Street

Nov. 1, 2005 - Scottsbluff
Western Nebraska Community College
WNC Harms Advanced Technology Center
2620 College Park

Nov. 2, 2005 - North Platte
Mid-Plains Community College
601 West State Farm Road

N**ov. 3 - Broken Bow** *(a.m.),* **O'Neill** *(p.m.)*
November 4 - Columbus
Visit **http://www.unicam.state.ne.us/committees/mrac.htm** for updated information, agendas, etc.

Better understanding of how Americans die: *development of a data collection and evaluation project to improve healthcare at the end of life*

By Jon Krutz

In 2003, the Institute of Medicine released a report entitled, Describing Death in America: What We Need to Know, which noted a significant need to improve both the capacity and systems necessary to collect data for better assessing the quality of end-of-life care for terminally ill patients (and their families). Currently, there is little understanding with regard to the following issues: in what environment do patients die; who cares for them as they are dying; what care guidelines are being followed, or rather what standards of care they are receiving; and whether or not care has changed over time. The lack of this data affects the ability of clinicians, providers, insurers and regulators to achieve their own goals, and does little to inform a coherent national end-of-life policy agenda. Obtaining this data for both quality of care and quality of life purposes is increasingly necessary since, in part, 75% of all deaths today are the result of chronic, eventually fatal illness. Additionally, patient and family healthcare preferences at the end-of-life are frequently left unmet.

With congressional support of FY 2006 funding through the Administration on Aging, the Nebraska Hospice and Palliative Care Association want to launch the development of a Nebraska-based data collection program to explore the following issues:

- What can be learned from existing data sources that can be better utilized to help explain disease trajectories, resource utilization, and care transitions based on a comparison of care in multiple settings;
- How can the existing data sources be available and accessible on a website to all who are looking for information about dying in Nebraska – care providers, health care professionals, consumers, researchers and students;
- What supplemental information is essential to enhancing quality of care and informing future decisions relative to the delivery of hospice or palliative care that is not currently being collected. Types of information not currently collected includes: next-of-kin exit surveys, measurements on childhood deaths, types of supportive services used and cultural issues;
- New or additional data concerning, for example, pain and shortness of breath symptoms, mental and psychological functioning, patient satisfaction as it relates to quality of care or data concerning goals of care, and grief assessments.

This initiative seeks both to obtain more accurate and comprehensive end-of-life data at the state and local level and to disseminate it more widely. For more information, contact: Jon Krutz at NebraskaHospice@aol.com, (402) 540-3128. □

Kellogg Foundation chooses Nebraska initiative for national grant

Reprinted with permission from Nebraska Community Foundation *Connections,* Summer 2005.

Hometown Competitiveness, a Nebraska initiative of the Nebraska Community Foundation and three partners, ahs been chosen as one of six recipients of grants provided through the W.K. Kellogg Foundation's 75th Anniversary Entrepreneurship Development Systems for Rural America.

The $2 million award, over three years, was approved by the Kellogg Foundation Board of Directors meeting at Battle Creek, MI in April. More than 180 applications were received for the grants to develop six national models in rural entrepreneurship. HomeTown Competitiveness (HTC) provides a framework for rural communities to help them identify reachable goals and strategies focus on the four pillars of reversing rural decline, including building leadership and community capacity, engaging young people, fostering local philanthropy, and supporting entrepreneurship.

The core partners in the Kellogg-funded initiative with the Nebraska Community Foundation are the Heartland Center for Leadership Development, the RUPRI Center for Rural Entrepreneurship and the Center for Rural Affairs.

Other collaborative partners are colleges and programs at the University of Nebraska; the Nebraska Microenterprise Partnership Fund; Northeast Community College at Norfolk; Northern Great Plains, Inc., of Fargo, ND; the Nebraska Lied Main Street Program; the Rural Enterprise Assistance Project; and Consolidated Telephone Company and Great Plains Communications, Inc, who serve the rural HTC communities.

Other Kellogg Entrepreneurship Development Systems grant recipients are located in Northern New Mexico counties, pueblos, and tribes; Oregon; the Pine Ridge and Cheyenne River reservations of South Dakota (Lakota Sioux), and the Wind River Reservation in Wyoming (eastern Shoshone and Northern Arapahoe); 11 counties in West Virginia, Kentucky and Ohio; and 85 rural counties of North Carolina.

For more information, contact Jeff Yost, President and CEO of the Nebraska Community Foundation at (402) 373-7332, or e-mail him at jeffyost@nebcommfound.org □

Preparing for Medicare Part D:

By Keith J. Mueller, Ph.D., and Lisa Bottsford, B.H.R.F.S.

The Time is Now: Milestone Dates 1
Note: *Dates correct at time of publication.*

September 2005
1st – Nov. 15th Medigap insurers send notices informing policyholders of their options.
1st – Nov. 15th Employers/unions notify insured retirees about their new prescription drug choices.

October 2005
1st - Approved Part D plans begin marketing.
13th - The Centers for Medicare & Medicaid Services (CMS) begins disseminating information describing Part D through the Medicare & You 2006 handbook, 1-800-MEDICARE, a Drug Plan Comparison Web Tool, and a Medicare Personal Plan Finder on Medicare.gov.
27th - CMS mails auto-enrollment information to dual eligibles.

November 2005
15th - Enrollment period begins.
15th - States and entities offering drug coverage provide written disclosure to Part D eligible individuals regarding actuarial equivalence.

December 2005
31st - Medicaid drug coverage ends for full benefit dual eligibles.

January 2006
1st - CMS Benefits Enrollment Urgency advertisement begins.
1st - Part D coverage begins for all beneficiaries enrolled in a plan.
1st - Dual eligibles' auto-enrollment takes effect.
1st Subsidies begin for Part D coverage for those eligible based on income and resources.
1st - Medigap insurers prohibited from selling new policies with drug coverage.

March 2006
1st – 31st CMS identifies all beneficiaries not enrolled in a Medicare prescription drug plan.

April 2006
1st – 30th CMS mails spring enrollment reminder to beneficiaries.
1st – 30th CMS facilitates enrollment in a prescription drug plan for those determined to be eligible for subsidies but who have not yet enrolled in a plan (through May).

May 2006
16th - Late enrollment penalty begins.

For more information about the Center and its publications, please contact the RUPRI Center for Rural Health Policy Analysis, 984350 Nebraska Medical Center, Omaha, NE 68198-4350. (402) 559-5260. http://www.rupri.org/healthpolicy □

AHRQ *cont'd. from page 3*

is private and secure, Shank said. That means making sure that only credentialed, authorized personnel with a valid reason to see a patient's health records get to see them, Shank said.

Implementation will extend beyond 3 years, she and Frances said. This grant provides crucial funding that will lay the foundation for on-going developments. Much remains to be learned in this phase, they explained. "There are a lot of unknowns that people will be looking to us for," Shank said. "Once you start down this road, it's an evolutionary project. A lot of what we have to learn we are making up—in the best sense of that phrase—along the way."

Five short-term objectives include the following:

1. All hospitals and physicians in the Panhandle have access to the Regional West Medical Center portal.
2. Working with all hospitals and clinics to implement electronic medical records in their facilities. Not many hospitals have fully implemented electronic medical record systems. Part of the project is to help those hospitals implement systems through exploration and bidding for the most economic routes to do so.
3. Identifying ways to benefit from economies in purchasing and maintaining electronic medical record systems. "These systems are fairly costly to implement," Shank said. "We are not ripping and replacing." Instead, an attempt will be made to build on what is already existing, even though not all systems are the same.
4. Sharing of such data as lab results, medications, and hospital discharge information on a patient, which are collected by physicians, hospitals, clinics, and other healthcare entities.

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Meth: America's homegrown drug epidemic

"Methamphetamine has become the most dangerous drug problem of small-town America," according to the U.S. Drug Enforcement Administration.[1] It seems to hit small towns more than big cities.

Created in neighborhoods across the country, methamphetamine (meth) is American's homegrown drug epidemic. It's sweeping the Nation from the California coast to the eastern seaboard. Meth is leaving a path of destruction, particularly among small towns, where youth are more than twice as likely to use the drug than young people living in larger cities.

What is meth?

"Meth is highly addictive. People who think they might use meth only once or twice can get hooked.

This powerful drug works in the brain and gives users a sense of energy that can make them push their bodies faster and further than they are meant to go. Even small amounts of meth can cause a person to be more awake and active, but it also makes people lose their appetite and become irritable and aggressive. Meth also causes a person's blood pressure to increase and heart to beat faster.[2]

Why are small towns more affected?

Most drugs—such as cocaine or heroin—come from other countries and are sold by dealers. Meth can be cooked at home in kitchens and garages, in vacant barns, and in other buildings. It is created with common household items such as batteries and cold medicine. These items are cheap and can be bought in local stores. The chemicals in them can pollute neighborhoods and make the environment unsafe for kids.

Treatment for meth use can be hard to find in small towns. Rural communities often have fewer health facilities and treatment options than larger cities. This means that youth and adult meth users may find it hard to get the help they need.

How many people are using it?

Numbers on meth use can be deceiving. While statistics show that use among teens and middle school students has been the same for the past few years, those numbers don't tell the whole story. Meth seems to spread in pockets, leaving some areas or populations nearly untouched while others are devastated.[3]

Why would anyone use meth?

Some people use it for the strong "rush" they get when they smoke or inject the drug. Other people use meth to help them lose weight or give them an energy boost so they can work more. Athletes and students sometimes begin using meth because it makes them feel like they are doing better in sports or schoolwork. At first, meth gives them more energy to practice sports and to study for longer periods of time.

What are the effects of meth use?

When the high wears off, people who use meth go through a severe "crash."

Recent studies have shown that meth causes more damage to the brain than alcohol, heroin, or cocaine.[6]

Because meth can be made from lethal ingredients like battery acid, drain cleaner, lantern fuel, and antifreeze, there is a greater chance of having a heart attack, stroke, or serious brain damage with this drug than with other drugs.4 Long-term meth use can result in fatal kidney and lung disorders, brain damage, liver damage, chronic depression, paranoia, and other physical and mental disorders.[5]

How can you tell if someone is using meth?

Symptoms of meth use may include[7]:

- Inability to sleep
- Increased sensitivity to noise
- Nervous physical activity, like scratching
- Irritability, dizziness, or confusion
- Extreme anorexia
- Tremors or even convulsions
- Increased heart rate, blood pressure, and risk of stroke
- Presence of inhaling paraphernalia, such as razor blades, mirrors, and straws
- Presence of injecting paraphernalia, such as syringes, heated spoons, or surgical tubing.

For treatment options, call your local health department, family doctor, or health care provider.

Meth use poses a real and growing threat to individuals, families, and communities across the country. Talk with your children about the dangers of using meth and help them find safe ways to "boost their energy." For example, they can take a 15-minute power nap after school, eat a high-energy snack, or exercise for 30 minutes. Meth is sweeping the Nation, but you have the power to prevent it from reaching your family.

Reprinted from *A Family Guide to Keeping Youth Mentally Health and Drug Free* at http://family.samhsa.gov/talk/drugepi.aspx

Sources and Additional Resources:

- Substance Abuse and Mental Health Services Administration. April 23, 2003. *The NCADI Reporter.* Get Up to Speed on Methamphetamine Abuse, last referenced 7/14/2005.
- Substance Abuse and Mental Health Services Administration. March 9, 2001. Prevention Alert. Meth: What's Cooking in Your Neighborhood?, Volume 4, Number 5. last referenced 7/14/2005.
- Substance Abuse and Mental Health Services Administration. 2002. Meth: What's Cooking in Your Neighborhood?, last referenced 7/20/05. (Also available as a print publication.)

Nebraska Rural Health Association presents Awards for Outstanding Rural Health Actions

Awards for Outstanding Rural Health Actions were presented at the 2005 Nebraska Rural Health Association Conference held in Kearney, September 8 and 9. The awards recognize individuals who take on leadership roles and who make a difference in health care in rural Nebraska.

"There are few things more gratifying than the approval and recognition of our peers for a job well done," said Marty Fattig, Nebraska Rural Health Association president and Nemaha County Hospital Administrator. "That's why it is an honor to recognize these people for their work in the health care field - literally on the frontier in the rural areas of Nebraska."

The awards were presented during the Awards Banquet held Thursday evening, September 8.

Senator Ben Nelson received the President's Award for his work on federal legislation related to rural health care.

"Nebraska has a large amount of rural geography providing unique challenges," said Dennis Berens, Director, Department of Health and Human Services, Office of Rural Health. "For this reason it's very important that we recognize the individuals that are helping meet those challenges by providing quality care."

Other award recipients were:

Integrated Rural Healthcare Award – Denise Christensen, Kearney

Outstanding Rural Health Practitioner Award – Judy Hayes, Kearney

Rural Health Distinctive Consumer Advocate Award – Cindy Scott, Juniata

Rural Health Achievement Excellence Award – Linda Welsch Jensen, Kearney

For more information on the award winners visit the Nebraska Rural Health Association's Web page at http://www.nebraskaruralhealth.org/index.html.

Awards and Recipients

The President's Award was presented to Senator Ben Nelson by Nebraska Rural Health Association President, Marty Fattig. Nelson staff members, Deb Cottier of Chadron and Kim Zimmerman of Washington, D.C., received the award on behalf of Senator Nelson.

This award acknowledges the Senator's work to improve access to health care in rural areas by ensuring that rural hospitals and providers have the resources they need to keep their doors open. As a native of McCook, Senator Nelson understands how important health care is to the survival of Nebraska rural communities.

Nelson has introduced legislation to overturn a federal regulation that lowered the reimbursement rate for rural hospital lab services.

The Senator was co-sponsor of legislation to create the new designation of "rural community hospital." This designation is for hospitals with between 25 and 50 beds. Under this proposal 15 rural community hospitals – including five in Nebraska – will receive cost-based Medicare reimbursements. This will allow them to recoup their costs of providing care as well as to maintain their facilities by making necessary improvements.

Under Medicare's complex funding formula rural states that were practicing cost-effective medicine, were reimbursed at a lower rate than urban hospitals. The senator voted for legislation to end this discrimination and supported legislation to equalize the reimbursement rate between urban and rural America.

Senator Nelson also co-sponsored legislation that provides a special visa to foreign doctors who agree to spend three years serving in a state. The Nebraska program has successfully retained 83 percent of physicians past their assigned term.

The Integrated Rural Healthcare Award is open to any provider of integrated primary care services in the rural areas of our state. It was awarded to Denise Christensen, coordinator for the Family Advocacy Center in Kearney since 2000. The advocacy center is a "one-stop shop" for child and adult victims of sexual abuse, physical abuse, and domestic violence serving 32 Nebraska counties, bringing together a variety of health providers to deliver quality care to survivors of abuse and to strengthen the bonds of the professional relationships in predominately rural areas.

The Outstanding Rural Health Practitioner Award recognizes an individual who is a direct service provider and who has exhibited outstanding leadership, care, and collaboration in improving health services in rural Nebraska. Judy Hayes, a registered nurse at Good Samaritan Hospital in Kearney, was recognized for more than 20 years in multiple areas of rural health care in southwest Nebraska. Hayes has worked in the areas of cardiac rehabilitation, obstetrics, home health, and hospice care.

Hayes is always ready to assist in all areas of healthcare, as well help maintain the economic viability of her home town of Cambridge.

Continued on page 11

NeRHA *cont'd. from page 10*

The Rural Health Distinctive Consumer Advocate Award recognizes the fact that rural health care delivery systems cannot survive without the involvement of committed advocates. Cindy Scott of Juniata won this award because of her powerful advocacy for mental health services for children, teens, and adults in Nebraska. She serves on boards, consumer councils, and executive committees for numerous state and national alliances for the mentally ill.

Exemplifying the Rural Health Consumer Advocate, Scott gives presentations in rural Nebraska about mental illness and service needs, and works with school administrators, teachers, and families of children with mental illness.

The Rural Health Achievement Excellence Award recognizes an individual in the health care industry for leadership and noteworthy initiative in promoting the development of community-oriented rural health care delivery. Linda Welsch Jensen of Kearney received this award for her leadership and advocacy for community-based, mental health services in central and south central Nebraska. Jensen helped organize the Drop-In Center as well as Psychiatric Day Rehabilitation Services in Kearney.

Encouraging increased services to persons with serious mental illnesses, she serves as an advisory council member of South Central Behavioral Health. She also works with the Buffalo County Community Partners' Mental Health and Suicide Prevention Task Force and the Housing and Homeless Coalition.

Currently, Jensen, a registered nurse, is on the Mental Health Alliance-Nebraska board of directors. She works as a coordinator for Family-Centered Maternity and Women's health care as the community liaison for the Psychiatric Nursing Care course. She also works as a graduate faculty member at the University of Nebraska Medical Center's College of Nursing in Kearney.

For more information on each award, contact Cindy Evert Christ, Nebraska Rural Health Conference Planner, nerhaconf@alltel.net □

MARK YOUR CALENDARS

Annual Minority Health Conference
October 25-26, 2005
Holiday Inn Central, Omaha, NE

Rural Health Advisory Commission Meeting
November 18, 2005 - 1:30 p.m.
State Office Building, Lincoln, NE

2006 Nebraska Family Health Conference
April 18-19, 2006
Holiday Inn, Kearney, NE

Annual National Rural Health Association Conference
May 16-19, 2006 - Reno, Nevada

Certified Rural Health Clinics Billing/Coding Workshops
September 5-6, 2006 (tentative)
Holiday Inn, Kearney, NE

Annual Nebraska Rural Health Conference
September 7-8, 2006
Holiday Inn, Kearney, NE

AHRQ *cont'd. from page 8*

5. Making prescription records part of the process, which includes pharmacies, to eliminate paper-based systems.

Whether going to a clinic, behavioral health provider, or a hospital—all of those provider organizations will be able to exchange information, Shank said. She offered this example of how the system could work: An unconscious patient is brought to the emergency room at the hospital in Chadron, with no information about medications the patient might be on or allergies that patient might be suffering. Through shared electronic health records under the plan for western Nebraska, emergency personnel at the hospital would have immediate access to that information.

What can be implemented quickly and safely will have immediate benefits for western Nebraska. "We will be sorting some of that out over the coming months," Shank said.

She and Frances emphasize that healthcare and information technologies evolve constantly, and the implementation plan developed in the Panhandle must accommodate that constant evolution.

As the executive summary states, this plan "is not a simple template that can or should be immediately adopted by other organizations." Rather, as stated elsewhere in the summary, it's a "living document" that will be modified and changed as deeper understandings, new information and new technologies are developed.

"This is obviously a great opportunity for western Nebraska," Shank said. At the same time, it is an endeavor also supported by partners at the state and local levels, she added. □

ACCESSory Thoughts

Dennis Berens, director
Nebraska Office of Rural Health

HEALTH WORKS

What an interesting set of words, with multiple meanings.

What is health, and what happens when everything works? What is our individual and collective role in this work? Is health care an economic engine or a vital public service within our state?

HealthWorks is the title of a national model to analyze the economic impacts of health care within a state. The Office of Rural Health contracts with the Nebraska Center for Rural Health Research at UNMC to run this model in Nebraska. To date we have completed the program in almost 50 counties within the state. You can find information about those counties at: http://www.unmc.edu/ruralNeRHW/reports/.

What have we learned from these studies? We learned that health care is a huge economic development resource, more than most people recognize. According to the center's findings, health care contributes about 228,000 jobs to our state's workforce and directly and indirectly has a financial impact of about $9.5 billion, based on 2002 figures.

Keith Mueller, the center's director, spoke at the state's annual Rural Health Conference about the impacts of healthcare in Nebraska. He said health care attracts highly skilled jobs to rural communities, contributes to the physical environment by its facilities, enhances the social environment through its workforce and activities and provides leaders for local governance as well as enhancing the health and personal growth of the people served. In other words, it is a very powerful force in Nebraska's rural communities.

Mueller challenged the conference participants to think about health care as an economic development train where it is an engine, the cars and the caboose. The role of the community is to ensure that it has laid down the infrastructure tracks for this train to run on.

It should also be noted that Nebraska has 537 communities of which 34 exceed 5,000 people. According to the census, 115 communities have between 800 and 5,000, and 384 have between 100 and 800 people. What will our infrastructure need to look like in the face of these demographics? Do we have any surplus health service capacity, the potential for extra business and, therefore, extra jobs for this economic engine? What new jobs should we be creating to meet our health needs and our job needs within our state? What is the public-private partnerships that will be needed to keep this engine running on updated tracks?

I have talked often about the need to have a Vision for what we want health care to be in our state. We now have an important set of economic numbers to discuss as we move to create this unified Vision around the idea that health works. The time is right for health care professionals and economic development professionals to come together to focus on the role of health care in our state's economy. It is time to act on the fact that health works. □

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